

HEALTH HISTORY

NAME: _____ **DATE:** _____

Please indicate if you have or have had any of the following:

Condition	Yes	No	Describe/When
Asthma	___	___	_____
Arthritis	___	___	_____
Blood Problem	___	___	_____
High Blood Pressure	___	___	_____
Cancer	___	___	_____
Diabetes	___	___	_____
Heart/Lung	___	___	_____
Muscle, Joint, Bone	___	___	_____
Stomach	___	___	_____
Stroke/TIA	___	___	_____
Physical/Sexual Abuse	___	___	_____

SURGICAL HISTORY: (If yes, when and what type)

Abdominal	___	___	_____
Bladder	___	___	_____
Uterine	___	___	_____
Prostate	___	___	_____
Bowel	___	___	_____
Orthopedic	___	___	_____
Spine	___	___	_____
Heart	___	___	_____
Lungs	___	___	_____
Plastic	___	___	_____
Any Other?	___	___	_____

Pregnancies: # _____ # Vaginal _____ #C-section _____

Please list current medications and allergies: _____

During the past month, have you often been bothered by feeling down, depressed or hopeless?
 ___ Yes ___ No

During the past month, have you often been bothered by little interest or pleasure in doing things?
 ___ Yes ___ No

Are you suffering? If so, how? _____

Please indicate your pain level below:

0 (none) 5 10(emergency)